

Montana WIC Program
Request for Medically Necessary WIC Approved Formulas



Participant Name: _____ Date of Birth: _____ Today's Date: _____

Please complete **Parts A and B** to prescribe a **Medical Formula**; complete **Part C** to prescribe **Goat's Milk** or **Soy Beverage** for a child.

A. Medical Formulas		
Please check the requested formula, specify the amount, include the diagnosis, and the length of time the formula is necessary. Prescribed Amount: <input type="checkbox"/> Maximum Allowable OR _____ per day		
Type of Formula: Hypoallergenic Formulas <input type="checkbox"/> Alimentum <input type="checkbox"/> Nutramigen Enflora <input type="checkbox"/> Pregestimil <input type="checkbox"/> Elecare <input type="checkbox"/> Neocate	Diagnosis <input type="checkbox"/> Milk and/or soy protein allergy and/or <input type="checkbox"/> Malabsorption and/or <input type="checkbox"/> Other: _____	Length of Time Formula is Required <input type="checkbox"/> 1 Month <input type="checkbox"/> 4 Months <input type="checkbox"/> 2 Months <input type="checkbox"/> 5 Months <input type="checkbox"/> 3 Months <input type="checkbox"/> 6 Months
Premature Infant Formulas <input type="checkbox"/> Enfacare <input type="checkbox"/> Neosure (Expert Care)	Diagnosis <input type="checkbox"/> Prematurity	Length of Time Formula is Required <input type="checkbox"/> _____ Month(s) <input type="checkbox"/> To 9 Months of age
Formulas for Children 1-5 years <input type="checkbox"/> Pediasure <input type="checkbox"/> Pediasure with Fiber <input type="checkbox"/> Similac Advance <input type="checkbox"/> Similac Sensitive <input type="checkbox"/> Similac for Spit-Up <input type="checkbox"/> Enfamil Prosobee <input type="checkbox"/> Other: _____	Diagnosis <input type="checkbox"/> Tube Feeding <input type="checkbox"/> Oral Motor Feeding Problems <input type="checkbox"/> Increased calorie needs due to a medical condition: _____ Continued need for standard infant formula due to: <input type="checkbox"/> Tube Feeding <input type="checkbox"/> Oral Motor Feeding Problems <input type="checkbox"/> Premature Infant	Length of Time Formula is Required <input type="checkbox"/> 1 Month <input type="checkbox"/> 4 Months <input type="checkbox"/> 2 Months <input type="checkbox"/> 5 Months <input type="checkbox"/> 3 Months <input type="checkbox"/> 6 Months <input type="checkbox"/> To the end of certification <input type="checkbox"/> To 1 year adjusted age
Other Medical Formulas <input type="checkbox"/> Other: _____	Diagnosis <input type="checkbox"/> Other: _____	Length of Time Formula is Required <input type="checkbox"/> _____ Month(s)
B. Supplemental Foods (for Infants 6 months and older, Children and Women)		
Please review the food packages to be issued on the back and check the appropriate issuance for the participant below.		
Infants (6-12 months) <input type="checkbox"/> Provide full food package <input type="checkbox"/> Do not provide any foods at this time; issue medical formula only <input type="checkbox"/> Provide a modified food package including the foods checked below: <input type="checkbox"/> Infant cereal <input type="checkbox"/> Infant vegetables/fruit	Children and Women <input type="checkbox"/> Provide full food package <input type="checkbox"/> Do not provide any foods at this time; issue medical formula only <input type="checkbox"/> Provide a modified food package including the foods checked below: <input type="checkbox"/> Low-Fat Milk <input type="checkbox"/> Whole Milk <input type="checkbox"/> Cheese <input type="checkbox"/> Soy Beverage <input type="checkbox"/> Juice <input type="checkbox"/> Cereal <input type="checkbox"/> Eggs <input type="checkbox"/> Fruits/Vegetables <input type="checkbox"/> Peanut Butter <input type="checkbox"/> Dry/Canned Beans <input type="checkbox"/> Bread/Brown Rice/Tortillas <input type="checkbox"/> Tuna/Salmon	Special Instructions/Restrictions
C. Soy Beverage and Goat's Milk for Children (Request is for 1 year, unless otherwise noted)		
<input type="checkbox"/> Issue soy beverage as a milk substitute for a child with a qualifying condition of milk allergy, lactose intolerance or vegan diet. <input type="checkbox"/> Issue goat's milk as a milk substitute for a child with a qualifying condition of intolerance to cow milk.		

Health Care Provider Name (Printed): _____ (Signature): _____ Phone Number: _____

Montana WIC Program
Prescribing Medical Formula and Supplemental Foods
for Montana WIC Participants



WIC participants with qualifying medical conditions are eligible to receive medical formula with the maximum amount based on the participant's age and category. Infants six months and older, children and women may also receive supplemental foods for their category, as listed below.

If a participant may receive the full amount of formula as listed below, please check the "Maximum Allowable" box under Medical Formula (Part A) on the front page. If a participant is to receive less, please designate the prescribed amount in the same box.

For Supplemental Foods, Part B, please review the WIC supplemental foods below and indicate on the front page which foods are most appropriate for the participant to receive. If a participant may receive the full food package, please mark the box indicating this. If a participant may receive a modified food package, please check the foods the participant may receive from the list on the front page.

	0-3 months	4-6 months	7-12 months	7-12 months (when solids are contraindicated)
Medical Formula:				
Powder (reconstituted)	Up to 870 oz.	Up to 960 oz.	Up to 696 oz.	Up to 960 oz.
Concentrate (reconstituted)	Up to 806 oz.	Up to 884 oz.	Up to 624 oz.	Up to 884 oz.
Ready-to-feed	Up to 832 oz.	Up to 896 oz.	Up to 640 oz.	Up to 896 oz.
Infant Foods:				
Infant Cereal	None	None	3 8-oz. containers	None
Infant Vegetables/Fruits	None	None	32 4-oz. jars	None

Children 1-5 years
Up to 910 oz. formula
4 gallons milk or 3 gallons milk and 1 lb. cheese
2 64-oz. bottles juice
36 oz. cereal
1 dozen eggs
\$6 fruit and vegetable benefit
18 oz. peanut butter (for children 2 years and older) or 1 lb. dry beans or 4 16-oz. canned beans
2 lb. whole wheat bread or brown rice or whole wheat tortillas or soft corn tortillas

Fully Breastfeeding Women	Pregnant or Substantially Breastfeeding Women	Partially and Non- Breastfeeding Women
Up to 910 oz. formula	Up to 910 oz. formula	Up to 910 oz. formula
6 gallons milk and 1 lb. cheese or 5 gallons milk and 2 lb. cheese	5 1/2 gallons milk or 4 1/2 gallons milk and 1 lb. cheese	4 gallons milk or 3 gallons milk and 1 lb. cheese
3 12-oz. frozen Juice	3 12-oz. frozen juice	2 12-oz. frozen juice
36 oz. cereal	36 oz. cereal	36 oz. cereal
2 dozen eggs	1 dozen eggs	1 dozen eggs
\$10 fruit and vegetable benefit	\$10 fruit and vegetable benefit	\$10 fruit and vegetable benefit
18 oz. peanut butter AND 1 lb. dry beans or 4 16-oz. cans beans	18 oz. peanut butter AND 1 lb. dry beans or 4 16-oz. cans beans	18 oz. peanut butter or 1 lb. dry beans or 4 16-oz. cans beans
1 lb. whole wheat bread or brown rice or whole wheat tortillas or soft corn tortillas	1 lb. whole wheat bread or brown rice or whole wheat tortillas or soft corn tortillas	None
30 oz. tuna or pink salmon	None	None

Please contact your local WIC agency with any questions.